PUTNAM COUNTY EMERGENCY MEDICAL SERVICES

270 CARLEN DRIVE; COOKEVILLE, TN 38501
(931) 528-1555 FAX (931) 372-0295

Signature form

Patient's Name: _____ Run Number: _____

Date: _____/_____/_____

The patient or family should sign this section if possible. If the patient is not able to sign, a friend, nurse or even a bystander may sign this section. No financial responsibility is incurred by the signer when signing above the bold line.

Crew Initials: _____
A copy of the NPP was left with the patient.

☐ **Notice of Privacy Practices (NPP)**
I acknowledge the patient has received the NPP

☐ **Acknowledgement of Transport to bill Insurance**
Putnam County Emergency Medical Services (PCEMS) transported the patient cited above on this date. PCEMS has acquired the right, by provision of service, to bill insurance for the services provided and receive assignment.

X _____ Received by: _____

The patient and/or the nearest relative will sign this form if any of the following situations are applicable. Please check the applicable statements.

Hospital to Hospital

☐ Medicare and most private insurances will not pay for ambulance transportation to another hospital if the indicated procedures/treatments are available at this facility. I understand that I will be responsible for all charges incurred in the event that insurance does not reimburse PCEMS.

Doctor's Office

☐ I understand that Medicare and most private insurances will not pay for ambulance transportation to a physician's office. I understand that I will be responsible for all charges incurred in the event that insurance does not reimburse PCEMS.

Transport to other than nearest facility

☐ I understand that Medicare and many private insurance companies will not pay for ambulance transportation to facilities other than the nearest hospital. I understand that I will be responsible for all charges incurred in the event that insurance does not reimburse PCEMS.

Release of Liability

☐ I _____ acting as the patient, responsible party or relative of the patient, do hereby release from all liability, Putnam County Emergency Medical Services and it's employees, that might arise from the transport of this patient to another hospital other than the nearest medical facility. It is recommended by Putnam County Emergency Medical Services and it's employees that each patient be evaluated at the nearest medical facility and stabilized. Transfer to another medical facility can then be arranged. I understand that the Paramedic may elect to divert to the nearest medical facility if the patient's condition is not stable for transfer in the best judgment of the attending Paramedic or EMT.

Release of information, responsibility for bill

☐ I authorize the release of any information necessary to process this claim. I assign all medical benefits to PCEMS. I herby agree to pay collection expenses of 40% of the unpaid balance of my account in the event of my default or failure to pay. My account shall be considered in default if not paid in full within 90 days from the date services are rendered. The collection expenses shall include either or both collection agency fees and /or attorney's fees. I further state that I have read and understand the above statements.

X_____ Relation: _____